STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	06/13/2011

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NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN47630

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F0000	This visit was for the Recertification and State Licensure Survey. Survey Dates: June 6, 7, 8, 9, 10, and 13, 2011 Facility number: 000245 Provider number: 155354 AIM number: 100290800 Survey team: Terri Walters, RN TC Carole McDaniel, RN Elizabeth Harper, RN Martha Saull, RN 6/6, 6/7, 6/8, 6/10, 6/13/11 Census bed type: SNF/NF: 106 Total: 106 Census Payor type: Medicare: 4 Medicaid: 73 Other: 29 Total: 106 Sample: 22 Supplemental sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and / or execution of this Plan of Correction general, or any other corrective action set forth herein, in particular, does not constitute an admission of agreement by Newburgh Healthcare of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or excuted solely because of provisions of federal and or State law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on June 16, 2011 by Bev Faulkner, RN			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to ensure restraints were necessary and reduction attempts were made when possible for 1 of 3 residents reviewed for restraints in a sample of 22. Resident #105 Findings include: The care of Resident #105 was observed during transfer from bed to chair on 6/8/11 at 11:45 A.M. CNA #3 and CNA #4 applied a wide belt restraint to the resident's waist which secured him to the chair. The resident did not have the hand or arm strength to assist the CNAs and was able to bear partial weight, heavily depending on the aides to bear most of his weight. The CNAs indicated the resident did not attempt to get up himself and had not fallen that they knew of. CNA # 3 attributed the resident not having fallen "cause he has this to keep him safe," referring to the belt the aides were applying. They indicated the resident did	F0221	I. Corrective ActionResident # 105 will be observed and reviewed again for restraint reduction. Physical therapy will screen for evaluation of services.II. Others Having the Potential to be AffectedAll residents with restraints will be reviewed for clarity of documentation and alternatives trialed. The plan of care will be updated accordingly.III. Measures / Systemic ChangesAn inservice will be held for licensed nurses to review restraint documentation to include completetion of all areas of the assessment; analyzing data; clarifying conflicting scores; documenting justification related to medical symptoms; and attempts made at reduction.IV. MonitoringThe Assistant Director of Nursing will monitor for completetion of documention monthly. A note will be made in the medical record weekly when the restraints are reviewed. Any changes at this time will be noted and the plan of care will be updated accordingly.A summary of this monitor will be noted in the Quality Assurance Committee	07/13/2011

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	not lean forward or slouch in the chair. The clinical record of Resident #105 was reviewed on 6/07/11 at 10:45 A.M. Diagnosis included but were not limited to Senile Dementia and Alzheimer's Disease. The Minimum Data Set Assessments (MDS) of 4/19/11 and 1/17/11 indicated the resident had severely impaired skills for daily decision making and had not fallen for the past 6 month period. The MDSs identified daily restraint in use, non ambulatory, and total dependence of 2 staff for transfer. Documentation was lacking to indicate the resident made attempts to be up without assistance. The 7/28/09 Care Plan directed nursing to perform restraint assessments for possible restraint reduction. The Physical Restraint Elimination Assessment on 1/17/11 indicated a score of 17. The portion of the assessment that made assessment conclusions and drove action plans was blank with a line drawn through it. The portion which was blank included #1 "Candidate status as determined by TOTAL SCORE on reverse. Check box for Priority, Good or Poor based on the score." The resident's total score of 17 fell in the range of 0-20, which indicated the resident was a priority		meeting minutes quarterly. This monitor is ongoing.V. Completion DateJuly 13,2011	

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	candidate to eliminate his restraint. On the assessment date of 4/19/11, on the same form, the resident scored a total of 14 indicating he continued to be a priority candidate for restraint elimination, but that portion again was not completed. The 4/19/11 assessment also had a section which was completed. It contained the question "Candidate for restraint reduction or elimination program?" to which the assessor responded by checking "No" without rationale provided with a score of 14. There was a comment written "Continue present plan of care, resident has a diagnosis of Alzheimer's." The form directed if the No response was chosen for the resident not being a candidate (as it had been) state specific reason, medical symptoms or targeted behaviors. The space provided to comply with that direction was left blank. In the next section there was a spot for additional comments in which the assessor wrote "continue with soft belt while up in wheel chair. Unable to comprehend safety awareness." Documentation was lacking to indicate the resident attempted to be up without assistance or was engaging in unsafe behaviors or assuming unsafe positions for which enhanced supervision and/or positioning devices were unsuccessful. Documentation of trial restraint			

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	elimination being attempted was lacking. On 6/13/11 at 1:00 P.M., the Director of Nursing was interviewed and was unable to provide any additional information or documentation to review related to the restraint. 3.1-26(r) 3.1-3(w)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review and interview, the facility failed to ensure use of the correct resident's insulin was administered during 1 of 2 insulin administrations observed involving 1 of 2 residents receiving insulin from a supplemental sample of 7. Resident # 36 Findings include: On 6/7/11 at 4:50 P.M., LPN #2 was observed administering insulin to Resident #36. She drew up and correctly administered 2 units of Novolog insulin based on a sliding scale of 2 units of insulin for coverage of a blood sugar of	F0281	I. Corrective ActionThe facility will purchase a new vial of Novolog insulin for resident # 30. Nurse # 2 is no longer employed at the facility.II. Others Having the Potential to be AffectedAll residents have the potential to be affected. Nurse # 2 is no longer emplyed at the facility. There have been no other observations of this practice.III. Measures / Systemic ChangesAn inservice will be held to review the facility policy on medication administration and th 5 rights of medication administration.IV. MonitoringThe medication administration pass will be monitored at random daily for two (2) weeks by the Staff	07/13/2011

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	161. She read and checked the insulin bottle label against the MAR(Medication Administration Record) to ensure the drug was correct and the dosage was correct. The nurse failed to check the label on the box, which held the bottle of Novolog. The box label indicated the Novolog belonged to Resident # 30. The label directed that Resident #30 was to be given 1 unit for sliding scale coverage of a blood sugar of 161. When informed of the supply error the nurse indicated "Well at least it's the right medication and it won't hurt her. I didn't read it didn't belong to her." The nurse checked the medication cart and indicated she did have the supply of Resident #36's Novolog on hand but had chosen the wrong box. The clinical record of Resident #36 was reviewed on 6/7/11 at 5:15 P.M. It contained a 6/03/11 physician order for sliding scale Novolog insulin before meals and at bedtime for a dose of 2 units to cover a blood sugar from 151-200. The related facility policy and procedure was reviewed on 6/09/11 at 9:50 A.M. The undated Policy and Procedure IIA2: Medication Administration- General Guidelines part A. 3 directed "Prior to administration, the medication and dosage schedule on the resident's Medication		Developement Coordinator, Assistant Director od Nursing, or Directior of Nursing. Afterwards it will be monitored monthly by the pharmacy Nurse Consultant x six (6) months. This monitor will be reviewd in the first quarterly Quality Assurrance Committee meeting for patterns, trends, and revision of the monitor.V. Completetion DateJuly 13,2011	

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	Administration Record (MAR) is compared with the medication label. 3.1-35(g)(1)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure physician orders were followed for 1 of 1 residents reviewed for pommel cushion and Dycem placement in a sample of 22. Resident #69 Findings include The clinical record of Resident #69 was reviewed on 6/7/11 at 9 A.M. Diagnoses included, but were not limited to, the following: Alzheimer's Disease, anxiety and mood disorder. The most recent MDS (Minimum Data Set assessment), dated 5/17/11, indicated the following for the resident: severe cognitive impairment, trunk restraint in place (physical restraints are any manual or physical or mechanical device, material and/or equipment attached and/or adjacent to the resident's body that the individual	F0282	I. Corrective ActionThe pummel cushion for resident # 69 was replaced afetr drying. Another pummel cushion will be provided for back-up. Physical therapy will also screen to determine an alterbnative to the pummell cushion.A note will be made on the TAR to reflect the absence of the pummel cushion on 6/7/11 and 6/8/11.II. Others Having the Potential to be AffectedThere are no other residents that use pummell cushion with dycem. All residents with seating devices will be reviewed and corrected as necessary.III. Measures / Syatemic ChangesAn inservice will be held with the nursing staff to review use of pummel cushion and other seating devices including the need for availability. Nursing staff will review the need to document accurately.IV. MonitoringThe unit managers will monitor for daily. All members of nursiing administration will observe during rounds.This will	07/13/2011

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	cannot remove easily which restricts freedom of movement or normal access to one's body). A Care Conference Summary, dated 5/24/11, included but was not limited to, the following: "This belt alarm is considered restraint d/t (due to) she is unable to remove it on command. A pummel (sic) cushion (wedge) with Dycem (material to prevent a resident from sliding) under it is used to help prevent her from sliding." A treatment record, dated June 2011, was reviewed with the clinical record. This record indicated the following "nursing measure" dated 7/8/09: "Place pommel wedge cushion in W/C (wheelchair) W (with) Dycem to prevent sliding self down in w/c (wheelchair). Check q (every) shift for proper placement." This intervention was documented as having been completed for 6/1/11 to 6/8/11. The June 2011 Treatment record also indicated the following with an initial date of 6/17/09: "Seat belt alarm on wheelchair as restraint due to decrease safety awareness, impulsive decision making skills. Check every hour and release every 2 hours for toileting or repositioning." This was documented as completed for 6/1/11 to 6/8/11.		be ongoing. An initial summary will be made for this monitor in the QA meeting. The monitor will be revised according to findings.V. Completetin DateJuly 13,2011	

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	On 6/7/11 at 8:45 A.M., the resident's care was observed. She was observed in her wheelchair with an alarmed seat belt in place. The resident was observed with her bottom towards the outer edge of the wheelchair seat, with her back slouched. As the resident was assisted to stand, no pommel wedge cushion or Dycem to prevent the resident from sliding out of a wheelchair was observed in the wheelchair. On 6/8/11 at 8:30 A.M., the resident was again observed in her wheelchair with an alarmed seat belt on . The resident was again observed with her bottom towards the outer edge of the wheelchair seat. CNA #1 and CNA #2 were attempting to assist the resident to stand. The resident refused. At this time, CNA #1 and CNA #2 were interviewed. They indicated the resident did not have any cushion or Dycem in the seat of the wheelchair. On 6/10/11 at 12:20 P.M., the DON (Director of Nursing) was interviewed. She was made aware of the resident not having had Dycem or a pommel cushion in her wheelchair seat. She indicated the resident tends to slide out of her wheelchair and sit with her bottom towards the edge of the wheelchair.			

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	3.1-35(g)(2)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure a resident did not acquire a pressure sore for 1 of 5 residents reviewed with pressure sores in a sample of 22. Resident #46 Findings include: 1. The clinical record of Resident #46 was reviewed on 6/6/11 at 12:30 P.M. Diagnoses included, but were not limited to, the following: osteoporosis and rheumatoid arthritis, Status Post left hip fracture. The MDS (Minimum Data Set assessment), dated 1/7/11, indicated the following: Total cognition score of 12,	F0314	I. Corrective ActionResident # 46 is receiving appropriate services at this time. The facility is unable to correct the previous assessment. This resident's skin assessment will be reviewed and update accordingly.II. Others Having the Potential to be AffectedA skin assessment will be completed for all residents at high risk for pressure ulcers, including surgical wounds.III. Measures / Systemic ChangesAn inservice will be held to review weekly skin assessments, including the assessment of resident with surgical wounds and documentation of the assessments.IV. MonitoringThe wound nurse will monitor skin assessments for high risk	07/13/2011

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	which indicated moderately impaired cognition; bed mobility and transfer required total dependence; walking in room and corridor did not occur; range of motion was impaired on one side to lower extremity; resident at risk for developing pressure sores; resident does not have one or more unhealed pressure ulcers currently; current skin and ulcer treatments included pressure reducing device for chair/bed; turning/repositioning program; nutrition and hydration intervention; Necrotic tissue (Eschar) is indicated as black brown or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding tissue. The CAA (Care Area Assessment), dated 1/8/11, included, but was not limited to, the following: requires max (maximum) assist with her ADLs (activities of daily living) and performing personal care; recent fall with left hip fractures follow therapy recommendations; currently using wheelchair for mobility; has complaints of hip pain; is at risk for skin breakdown related to incontinence of bladder and bowels, assess her skin for areas of concern during personal care. No skin pressure areas. An "Admission Nursing Assessment," dated 12/31/10, included, but was not limited to, the following: admitted from		residents weekly. The wound nurse will follow up with the unitmanger two (2) x a week on resident's with surgical wounds or resident's readmitted at high risk.The unit manager will observe the same mentioned residents daily. A summary of this monitor will besubmitted for The quarterly QA meeting. This monitor will be ongoing. Revisions will be made according to findings.V. Completetion DateJuly 13,2011	

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	(hospital name), diagnosis fractured left hip, no open areas were identified to the resident's left heel; partial weight bearing as tolerated; ambulation with 2 person assist. A Braden scale assessment for predicting pressure sore risk indicated the following: On 12/31/11 and 1/10/10, a total score of 14. According to the form a total score of 12 or under represents a high risk. Both assessments indicated the following: chairfast; very limited mobility; "Friction and shear: requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction." A Care Conference Summary, dated 1/11/11, indicated the following: "...returned to the facility from the hospital...on 12/31/10...in hospital...resulted in a hip fracture (left)...Currently requires extensive total care for ADLs and personal care...." Nurses notes, dated 12/31/11 at 2:15 P.M., indicated the following: "...alert with confusion...requires 2 assists for ADLs...."			

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Nurses notes, dated 1/6/11 at 8:05 A.M., indicated the following: "...Brace to L (left) leg in place...."

Nurses notes, dated 1/11/11 at 3:40 P.M., indicated the following: "Returned from (physician office name)...knee immobilizer for 3 more weeks...."

A physician order, dated 2/25/11 indicated the following: "OK to remove L (left) knee immobilizer at hs (bedtime)."

Nurses notes, dated 2/7/11 at 3 P.M. indicated the following: "...Requires 1 assist with ADLs/transfers...noted dkned (darkened) area on l (left) heel...knee high Ted (support hose) donned bilaterally...."

A "Pressure/...ulcer...documentation" form had an initial date of 2/7/11. This form indicated the following: "Site: l (left) heel pressure area, not present on admission; stage E (Eschar) size 3.0 length and width 3.5 cm (centimeters), color: black, Eschar." The form indicated the black Eschar remained until 5/9/11 when the following was documented: "length 0.7 cm x width 1.2 cm, depth 0.2 cm.; 50 % granulation tissue and 50% slough." The skin assessment, dated 6/6/11, indicated the following measurements: 0.5 cm length; 1.0 cm

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	width and 0.2 cm depth." On 6/8/11 at 2:20 P.M., the Pressure Ulcer Risk Assessment policy and procedure was received from the Wound Skin Nurse. This policy had the most recent revision date of March 2005. This policy included but was not limited to the following: "...The most common site of a pressure ulcer is where the bone is near the surface of the body including the...heels...Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown...Monitoring: Staff will perform routine skin inspections daily or every other day as needed...Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers...evaluation may identify pre-existing signs (such as purple or very dark area that is surrounded by profound redness...suggesting that deep tissue damage has already occurred and additional deep tissue loss may occur. This deep tissue damage could lead...or progression of a Stage I pressure ulcer to an ulcer with Eschar or exudate within days after admission..."			

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	On 6/13/11 at 10:30 A.M., the DON (Director of Nursing) was interviewed. She indicated the following: She only found one documentation in nurses notes of the resident having had support hose (TED) on. She indicated she also interviewed two staff who are presently here and care for the resident while she recovered from her hip fracture and they both stated the resident did not wear support hose. The DON indicated that when staff removed the knee immobilizer, they would have also assessed the resident's skin. The DON also provided documentation at this time from January 2011 for the following: "Knee immobilizer- remove for skin care." This was documented as done on each shift from 1/1 - 1/11/11. On 1/11/11 an order was received for "Knee immobilizer for 3 more weeks at hs (bedtime)." This was documented as being off at hs from 1/11/11 to the end of the month. Documentation was lacking of weekly skin assessments on 1/19/11 and 1/26/11. A skin assessment was completed on 2/2/11. 3.1-41(a)(1)			

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	155354	A. BUILDING 00 B. WING	06/13/2011

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F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to maintain a medication error rate of five percent or less; in that 3 medication errors in an opportunity of 50 were observed resulting in a 6% error rate. This affected 2 of 7 residents from a supplemental sample of 7. Residents # 111 and Resident # 114 Findings include: 1. On 6/7/11 at 9:05 A.M., QMA (Qualified Medication Aid) #1 was observed administering medications. During preparation of drugs for Resident #111, the QMA crushed to a fine powder and administered one Felodipine ER (extended release) 5 mg tablet and one Klor Con (potassium supplement) M10 meq (milli equivalents) ER. She indicated, at that time, pills were always crushed for the resident to facilitate swallowing and mixed with applesauce. The clinical record of Resident #111 was reviewed on 6/7/11 at 10:30 A.M. It	F0332	I. Corrective ActionResident # 111 and resident # 114 will have medication changed to liquid. Resident # 114 has expired. QMA #1 was inserviced immediatelyII. Others Having the Potential to be AffectedAny resident who requires medication to be crushed may be affected. All medications that are "Do Not Crush" will be reviewed by the pharmacist. III. Measures / Systemic ChangesQMA # 1 was inserviced immediately. An inservice will be held for QMA's and nurses regarding extended release medication and the "Do Not Crush" listing. Do not crush medications will be stickered for identification on the medication box and noted the Medication Administration Record. The listing will remain in the front of the Medication Administration Record.IV. MonitoringMedication pass will be monitored daily x two (2) weeks by the Staff Development Coordinator, Assistant Director of Nursing or Director of Nursing. Then monthly by the pharmacy Nurse Consultant. A summary of the findings will be submitted in the quarterly Quality Assurrance	07/13/2011

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	contained an 8/27/10 physician order for Felodipine ER 5 mg daily and a 12/22/10 order for Klor Con M10 ER daily. 2. On 6/7/11 at 9:20 A.M., QMA #1 was observed crushing to a fine powder, mixing in applesauce and administering Klor Con M10 meq ER to Resident #114. At the time of administration, the resident complained of nausea and ingested a portion of the crushed medication. The exact amount could not be exactly determined but appeared to be approximately half. The clinical record of Resident #114 was reviewed on 6/7/11 at 10:45 A.M. It contained a 5/27/11 order for Klor Con M10 ER daily. On 6/7/11 at 10:20 A.M., the facility consulting Pharmacist #1 was interviewed regarding the practice of crushing these medications. He indicated the drugs should be dissolved in water or given in liquid form. The facility drug reference book "Nursing 2012 Drug Handbook" was reviewed on 6/7/11 at 1:00 P.M. On page 1102 it indicated "Don't crush sustained release forms" in reference to Klor Con M 10 tablets. On page 574 of the same book it directed, when administering Felodipine,		Committee Meeting for revisions to the monitor. This monitor is ongoing.V. Completetion DtaeJuly 13, 2011	

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	"tell the patient to swallow tablets whole and not crush or chew them." The related facility policy and procedure was reviewed on 6/09/11 at 9:50 A.M. The undated Policy and Procedure IIA2: Medication Administration- General Guidelines part A. 5 directed "If it is safe to do so, medication tablets may be crushed or emptied out when a resident has difficulty swallowing...Long-acting or enteric coated dosage forms should generally not be crushed; an alternative should be sought." 3.1-25(b)(9)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure facility staff washed hands or changed gloves after touching	F0441	I. Corrective ActionA hand washing inservice was held to address the concerns for residents # 95, # 96, #28, # 36 and # 59. Gloves were replaced for resident # 28.II. Others having	07/13/2011

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	potentially contaminated items. This involved 4 of 15 staff observed for infection control practices (RN#1, QMA#1, QMA#2, LPN#1) and potentially affected 5 of 14 residents observed. (Resident #95, Resident #96, Resident #28, Resident #36, Resident #59) Findings: 1. On 6/7/11 at 10:00 A.M., RN #1 was observed administering medications. She took a dose card of Z-Pac antibiotic for Resident #95 from the cart. She dropped the card on the floor. She bent down to pick it up touching both bare hands to the floor. She removed the medication from the card, put it in a cup, administered medication to the resident and delivered the resident to an activity via wheel chair, all without hand cleansing. 2. On 6/7/11 at 11:30 A.M., QMA # 1 was observed preparing to perform a glucose level test on Resident #96. The QMA dropped her keys on the floor, picked them up with her gloves and continued to prepare for the test without hand washing. She replaced the keys into her uniform pocket. 3. On 6/08/11 at 8:15 A.M., QMA # 2 was observed preparing medications for Resident # 28. She indicated she needed to open capsules and wanted to handle them with gloves. She obtained gloves from a box of disposable plastic gloves, which were stored on the floor in front of the resident's room door as a door stop. In doing so, she handled the box from the floor, removed clean gloves (rendering them soiled by her hands) and put the box under her arm against her clean uniform, applied the gloves and used them to open capsules, crushed all pills and administered the medications.		the Potential to be Affected.All residents have the potential to be affected by this practice.III. Measures/ Systemic ChangesAn inservice will be held to review facility policies regarding hand washing glove removal and use; when to change gloves; recognizing "dirty" to clean when using gloves; holding items close to clothing; and disinfecting equipment used.A hand washing inservice will be held to include return demonstration and return demonstration of glove removal. The treatment nurse will demonstrate dressing change technique, including removal of gloves during the process. This will be included in the general orientation for nurses.IV. MonitoringThe wound Nurse and Staff Coordinator will monitor dressing changes weekly for three (3) months. New hires will demonstrate the technique during general orientation with the Staff development Coordinator. An inservice will be held two (2) times a year and as needed. A summary of the findings will be includeed in the quarterly Quality Assurance Committee meeting minutes.V Completetion DateJuly 13,2011	

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4. On 6/8/11 at 9:00 A.M., QMA #2 was preparing to medicate Resident #36. She dropped her stethoscope on the floor, picked it up and hung it around her neck. She picked up the cup of medications and administered them to the resident without hand washing or cleansing the stethoscope.

On 6/08/11 at 10:45 A.M., the Director of Nursing was informed regarding staff practices of failed identification of items on the floor as being dirty. She indicated need for staff re-inservicing.

5. Resident # 59's clinical record was reviewed on 6/6/11 at 1:00 P.M. His current Minimum Data Set Assessment (MDS), dated 5/17/11, indicated a severe cognitive impairment and a Stage 3 pressure sore.

The facility pressure ulcer documentation, dated 6/6//11, indicated a Stage 3 pressure sore, which measured 1 cm (length) x 2.5 cm (width) with a depth of 0.2 cm.

The current treatment order (initiated 2/14/11) for the right foot indicated to: clean the right foot 1st metatarsal head with normal saline. Then apply collagen and bactroban to wound bed. Cover with a non-bordered foam dressing and apply roll gauze and secure with tape daily. Cover with stockinet (dressing).

On 6/7/11 at 9:30 A.M., LPN #1 brought

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	supplies to the bedside to change Resident #59' s right foot dressing. Resident #59 was in bed at this time. LPN #1 opened gauze and foam dressing packages and placed a plastic bag and these open packages and scissors on the bed linen for preparation of the dressing change. LPN#1 indicated she was ready to start the dressing change. LPN #1, without hand washing, applied gloves and removed Resident #59's right foam boot and right sock. She then began cutting off the gauze dressing of the right foot and placed the dressing in a bag. She then removed her gloves and applied new gloves without hand washing. She cleansed the right foot wound by irrigating the wound with 2 ampules of normal saline. LPN #1 then applied the collagen dressing (with bactroban) and then applied a foam dressing. She then changed her gloves and wrapped the right foot with the gauze dressing and continued to finish treatment at the bedside. The facility policy "Dressings, Dry/Clean" was received and reviewed on 6/9/11 at 9:30 A.M. This policy included but was not limited to: "...7. Wash and dry your hands thoroughly. 8. Put on clean gloves. Loosen tape and remove soiled dressing. 9. Pull glove over dressing and discard into plastic or biohazard bag. 10. Wash			

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	and dry your hands thoroughly..." On 6/13/11 at 10:30 A.M., during interview with the Director of Nursing (DON), the policy "Dressings, Dry/Clean" was reviewed. The DON was made aware of LPN #1 not washing her hands before initiation of the dressing change and after removal of the soiled dressing. No additional information was provided by the DON at this time. 3.1-18(b)(2) 3.1-18(l)			